MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

| PART I: GENERAL INFORMATION | | | | |
|---|---|--|--|--|
| Type of Requestor: (x) HCP () IE () IC | Response Timely Filed? (X) Yes () No | | | |
| Requestor's Name and Address Vogue Medical Center | MDR Tracking No.: M4-03-6989-01 | | | |
| 5610-B Lemmon Avenue #100 Dallas TX 75209 | TWCC No.: | | | |
| Danas IA /3209 | Injured Employee's Name: | | | |
| Respondent's Name and Address Utica National Insurance | Date of Injury: | | | |
| PO Box 743488 Dallas TX 75374 c/o Box 28 | Employer's Name: Vantex Enterprises Inc | | | |
| Sumus IX 19574 Cro Box 26 | Insurance Carrier's No.: 869025 | | | |

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | - CPT Code(s) or Description | Amount in Dispute | Amount Due | |
|------------------|---------|-------------------------------|-------------------|------------|--|
| From | То | - Ci i Couc(s) of Description | Amount in Dispute | Amount Due | |
| 5-23-02 | 5-23-02 | 99070-ST | 558.02 | 0.00 | |
| 5-23-02 | 5-23-02 | 99499-RR | 450.00 | 0.00 | |
| 5-23-02 | 5-23-02 | 62282 | 400.00 | 0.00 | |
| 5-23-02 | 5-23-02 | 00630-47 | 300.00 | 300.00 | |

PART III: REQUESTOR'S POSITION SUMMARY

Sterile tray costs the provider the amount billed; patient spent time in recovery room under physician care; spine/injection lumbar and related costs; and reasonable and necessary treatment per patient's signs and symptoms.

PART IV: RESPONDENT'S POSITION SUMMARY

The provider submitted the bill with insufficient documentation for their charges. Provider did not support their charges or billed with the incorrect CPT code.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The 1996 Medical Fee Guideline applies to the disputed dates of service. 99070-ST was paid at fair and reasonable with denial code "M". Per Rule 133.307(g)(3)(C) the requestor did not document why the disputed fee warranted additional reimbursement and per section (g)(3)(D), the requestor did not discuss, demonstrate, and justify that the payment amount being sought is a fair and reasonable rate of reimbursement per Rule 133.1(8) and TLC 413.011. Therefore, no additional reimbursement recommended.

99499-RR was denied as not appropriately documented. This is a DOP code that requires documentation per General Instructions III. A. DOP requirements were not met. Recovery room time was not documented. Therefore, no reimbursement recommended.

62282 was denied per MFG surgery ground rule I. E. 4. c. Ground rule states that ESIs shall be billed with code 62289 only. Requestor did not bill per the fee guideline. Therefore, no reimbursement recommended.

00630 was denied as not appropriately documented (code does not reflect service provided). Anesthesia ground rule V. B. states that spinal epidural administered by the surgeon shall be reimbursed the basic anesthesia value only and modifier –47 shall be used. Recommend reimbursement of \$300.00.

PART VI: DETAIL FINDINGS (If needed)

| Date of | | Amount in | Amount | Date of | | Amount in | Amount | | | |
|--|-------------------|-------------------------------------|---------------------------------|-------------------|---------------------|--|-----------------|--|--|--|
| Service | CPT Code | Dispute | Due | Service | CPT Code | Dispute | Due | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | - | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | Left Column: | \$0.00 | | | |
| | | | | | Total A | Amount Due: | \$0.00 | | | |
| PART VII: CO | MMISSION DECI | SION AND ORDE | `R | | | | | | | |
| | | | | | | | | | | |
| | | | | | | etermined that the ince carrier to re- | | | | |
| plus all accrued | | | | • | days of receipt of | | amount | | | |
| Ordered by: | | | | | | | | | | |
| | | | | | 01- | 31-05 | | | | |
| Author | rized Signature | | Турес | l Name | | Date of Dec | ision | | | |
| PART VIII: YO | OUR RIGHT TO R | EQUEST A HEAI | RING | | | | | | | |
| | | | | | | | | | | |
| Either party to | this medical d | ispute may disa | gree with all or | part of the Dec | cision and has a | right to request | a hearing. A | | | |
| request for a h | earing must be | in writing and th | ne TWCC Chief | Clerk of Proceed | edings/Appeals | Clerk must recei | ve it within 20 | | | |
| nrovider and r | eceipt of this de | cision (28 Texa estin Representa | s Administrativ tives box on | e Code § 148.3 |). This Decision is | was mailed to | the health care | | | |
| provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box | | | | | | | | | | |
| (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals | | | | | | | | | | |
| Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. | | | | | | | | | | |
| request. | | | | | | | | | | |
| | • | | and Order shall | ll deliver a copy | y of their writte | n request for a | hearing to the | | | |
| opposing party involved in the dispute. | | | | | | | | | | |
| Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812. | | | | | | | | | | |
| | | | | | | | | | | |
| PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION | | | | | | | | | | |
| | | | | | | | | | | |
| I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box. | | | | | | | | | | |
| Signature of I | nsurance Carrie | r: | | | Date. | | | | | |
| Signature of Insurance Carrier: Date: | | | | | | | | | | |
| | | | | | | | | | | |